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in traumatic SCI and the benefit is difficult to be assessed.
Methods.– Retrospective study of patients admitted in PM&R hospitalization for neoplastic paraplegia during the last 10 years at Nantes.
Data collected.– Demographics, clinical (cancer ASIA impairment scale (AIS), survey), functional (functional independence measure (FIM), bladder management) and therapeutics (surgery, radiotherapy).
Results.– Twenty paraplegia patients were reviewed. Prostate cancer was the most frequent (35%). The patients were treated by surgery in 75% of case and by radiotherapy in 70%. At the beginning of inpatient rehabilitation, AIS grade patient status was: 6 AIS A, 2 AIS B, 7 C and 5 D. At the end of the stay, the number of ambulatory patients changed from 3 to 6, 8 patients were urinary independent and 8 showed an increase at their FIM scale. For 35% of patients, a pressure ulcer was present at admission. It was 12.5% among patients coming from neurosurgery, 33% of those coming from medicine units but 66% of those coming from oncology units or follow-up care units. The average of length of stay was 4 month. For the survivors, the median survival rate was 13 months.
Discussion.– In-hospital death rate is high, raising questions about PM&R hospitalization aims. The functional advances remain low, often restricted by pain and weakness. Bladder function evaluation is a PM&R specificity even if the number of patients becoming urinary independent remains modest.
In light of these findings, the PM&R care management criteria for metastatic paraplegia are progressively defined. They are based on well-defined goals, defined by contract; have to be achieved during a one-month stay. For our cohort, the duration of stay is too long, increased by ulcer pressure complications at admission. This fact underlines the need to create a network of competence to optimize patients' care from acute units to PM&R unit discharge.

doi:10.1016/j.rehab.2011.07.506

CO05-003–EN

Benefits of exercise for cancer patients

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No abstract provided.

doi:10.1016/j.rehab.2011.07.507

CO05-004–EN

Exercise therapy after breast cancer

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Most patients treated for cancer have a sedentary life. In a Canadian study [1] on more than 9000 patients having been treated for cancer, only 37.1% of the breast cancer patients reached the physical activity level recommended by the American Cancer Society.
Physical activity (PA) improves quality of life of patients with breast cancer and decreases the recurrence rate. This is clearly shown for instance in the "nurses' health study" [2], from a cohort of 121,700 women. It seems we have to offer exercise sessions to patients during and after their breast cancer treatment. Many studies showed the benefits of exercise programmes either in a structured group or at home. These programmes last two to six months and improve quality of life, fatigue and fitness. It remains difficult to build recommendations because of the great variability of the exercise programmes available.
Adherence to the programme is usually good during the study time, but once the experiment is over, physical activity practice decreases often quickly. The best studies in the literature do not give data over six months. They show a fair stability in physical capacity but a decrease of the daily physical activity amount. Adherence to exercise prescription should be a priority subject of research to achieve a sustainable improvement of the health status of these patients.
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doi:10.1016/j.rehab.2011.07.508

CO05-005–EN

Breast cancer related arm lymphoedema and supportive care in oncology

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Keywords: Lymphoedema; Physiotherapy; Multilayer bandaging; Elastic garment; Patient involvement

Breast cancer related arm lymphoedema (BCRL) remains a relevant complication although it occurs less frequently thanks to the sentinel lymph node biopsy.
When the BRRA is not treated, it can be responsible for severe limb swelling, skin fibrosis and high infection risk. This morbidity negatively affects quality of life.
The physical treatment is called complex decongestive physiotherapy. It is carried out in two successive phases: the first intensive treatment aims to reduce substantial lymphoedema volume and reduce the fibrous tissue. Manuel lymph drainage (MLD), multilayer bandaging, specific exercise, and skin care are needed. This treatment can be implemented either in hospital or at home.
The aim of the maintenance phase is to stabilize lymphoedeme volume, consisting of a combination of custom-made sleeve-and-glove compression garments worn during the day and self-bandaging technique if necessary. Frequency of MLD treatment depends on the swelling and on patient involvement. Meticulous skin hygiene is needed to avoid erysipela.
Patient education, regular activity and weight control are major component of lymphoedema management to permit better maintenance or lead to an improvement of the BCRL.

doi:10.1016/j.rehab.2011.07.509

CO05-006–EN

Urinary, anorectal and sexual assessment after pelvic cancer surgery

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Keywords: Pelvic cancer; Voiding dysfunction; Perineal pain

Urinary, anorectal and sexual complications are often observed after pelvic cancer surgery. These symptoms may be secondary to a tumor compression or a specific surgical trauma of autonomic and somatic pathways involved in the bladder, bowel and sexual control. Indeed, pelvic organs are very close and share the same innervation, which plays an important role in the detrusor contraction, erectile function, pelvic floor contraction and global pelvi-perineal sensory functions. Moreover, pelvic irradiation and/or chemotherapy following specific surgery can also lead to neurogenic (myelopathy and plexopathy) lesions of centers and/or motor/sensory pathways, which control bladder and rectal functions. Specific bladder and rectal lesions secondary to irradiation are very common (chronic radiation cystitis, radiation rectitis). Sexual dysfunction from radiation therapy includes erectile dysfunction and vaginal stenosis.
Urinary symptoms observed after pelvic surgery are principally characterized by voiding dysfunction with urinary retention or post void residual in case of neurogenic lesion. In some cases, overactive bladder symptoms (urge, frequency) are due to a radiation lesion of the bladder mucosa. Cystoscopy and urodynamic investigations are necessary to understand the different pathophysiological mechanisms of these symptoms. Treatment of urinary retention is usually self-intermittent catherization and anticholinergic drugs can be used in